Eating Disorders Prevention: Taking the Tiger by the Tail

DawnElla M. Rust and Lowell Caneday

Many individuals with an eating disorder have a problem identifying with the idea of being "real rather than ideal" (Boskind-White & White, 1983, p. 168). In fact, this pursuit of an "ideal" body has been linked to the development of the eating disorders: anorexia nervosa and bulimia nervosa (Collins, 1988). Mass media today portrays the ideal woman as lean, strong, and graceful. This expectation has both positive and negative consequences. On the positive side, more women are pursuing healthier lifestyles. On the negative side, women are becoming obsessed with exercise and diet which can lead to the development of unrealistic expectations of thinness. Recent articles and books have indicated the changing standard of thinness in American women as a culprit in the development of eating disorders (Rapheale & Lacey, 1992; Yates, 1992). Fontaine (1991) refers to this body standard as "the glamorization of thinness." As the Duchess of Windsor is reported to have said, "No woman can be too rich or too thin."

As early as 1979, Bruch contended that the media was responsible for promoting the view that one can only be loved and respected if one is very thin. Research (Silverstein, Peterson, & Perdue, 1986; Olgetree, Williams, Raffeld, Mason, & Fricke, 1990; Waller, Hamilton, & Shaw, 1992) is linking the development of eating disorders to the media. However, it is important to note that researchers are not showing causation. Perdue and Silverstein (1985) conclude that watching television does not cause eating disorders, but that it is not unreasonable to suggest that women struggle to attain the "ideal" feminine form seen on television. However, one does not have to read the research to learn of the media's role in the development of eating disorders, nor their life threatening consequences. The life and death of Karen Carpenter is a painful example of a relentless pursuit of thinness and a case history of the devastation of eating disorders.

Anorexia nervosa, characterized by extreme weight loss, poor body image, and irrational fears of obesity and weight gain, is estimated at one in every 100 females between the ages of 12 and 18. Ninety percent of those affected by the disease are female. Bulimia nervosa, a related disorder that is two to three times more common than anorexia, involves episodes of binge-eating followed by attempts to purge the food, typically through vomiting, fasting, or the use of diuretics or laxatives. Bulimia nervosa also is more prevalent in females than males (Richards, 1985).

The initial response to this problem has been the treatment of the disorder. Treatment most often is comprehensive and ongoing (Haller, 1992). However, treatment may not be successful. In such cases, individuals remain chronically symptomatic or, more tragically, die as a result of the damage. Though the mortality rate of bulimia nervosa is unknown, between 15% to 21% of patients with anorexia nervosa die from complications of the disease (House of

DawnElla M. Rust is a faculty member in the Department of HHP at Northeastern State University. Lowell Caneday is director of the School of HPEL at Oklahoma State University.

Representatives, 1987). Research has indicated that the earlier treatment begins, the better the chance of recovery (Doane, 1983). The best treatment for eating disorders involves prevention of the development of the disorders.

Prevention has been classified into three types: primary, secondary, and tertiary. The primary prevention of eating disorders involves preventing their occurrence altogether; in other words, to enable healthy, non-eating disordered people to remain healthy. Secondary prevention means promoting the early detection and prompt treatment of eating disorders, thereby increasing the chances of a quick and complete recovery. Tertiary prevention is aimed at reducing the impairment that may result from an eating disorder. With regard to psychiatric disorders, most of the emphasis has traditionally been on secondary and tertiary prevention (Shisslak, Crago, Neal, & Swain, 1987). This article will show that a focus of physical educators and coaches should be on the primary prevention of eating disorders.

Specialists tend to agree overwhelmingly that more research is needed to determine the nature of eating disorders (House of Representatives, 1987). In addition, strong education and prevention programs are recommended to alleviate the rising incidence of the disorders. The focus of these education and prevention programs should be the importance of proper eating habits and the harmful effects of dieting. According to the House of Representatives (1987) prevention programs need to concentrate on improving self-images and on dismantling societal obsessions with weight and unnaturally thin body images. The National Live Stock and Meat Board (1992) has recently developed such a program. *Mirror, Mirror* is a resource packet for school professionals to use with adolescents who have concerns about their body weight, shape and image. The primary goals of the program are to help adolescents develop a more healthy lifestyle and positive body image and to reduce their obsession for developing a "perfect" body weight or shape.

Nagel and Jones (1992) also recommend that professionals help adolescents resist societal pressures to conform to unrealistic standards of appearance, and provide guidance on nutrition, realistic body weights, and achievement of self-esteem, self-efficacy, interpersonal relations and coping skills. Lindsey and Janz (1985) contend that physical educators, dance educators, athletic coaches and trainers have an opportunity to recognize and aid students with eating disorders, and to prevent eating disorders. Unlike other disciplines, these fields are constantly teaching principles of fitness, nutrition, and weight control through specific course content and through personal examples as role models. Lindsey and Janz (1985) contend that by promoting a healthy but not unrealistically thin body, the health and fitness professions will be able to counter the barrage of media and cultural influences that promote "thin is in." A Round Table (1985) also suggests coaches need to know the symptoms and potential consequences of these disorders. The role of a coach places him or her in an excellent position to detect eating disorders and refer the student-athlete for counseling.

Anorexia nervosa and bulimia nervosa are complex and multidimensional; therefore, referral for professional assistance or assessment is essential for individuals displaying symptoms of eating disorders. However, parents, educators and other health professionals can take an active role in prevention. Bayer (1984) recommends the following considerations: (1) Help young people to feel good about themselves and to accept others; (2) Avoid driving individuals to excel beyond their capabilities in academic or other endeavors; (3) Provide individuals with an appropriate but not unlimited degree of autonomy, choice, respon-

sibility, and self-accountability for their actions; (4) Be alert to crisis in the life of a young person. Be available to talk over problems, providing support and encouragement; (5) Teach the basic principles of nutrition and exercise in school and at home; (6) Be careful when encouraging a person to lose weight. Communicate love and concern for the individual, regardless of weight; and (7) If an individual wants to begin a diet, find out why. If he or she feels inadequate or unaccepted, deal with these issues. If weight loss is called for, consult a professional.

Bayer's list of considerations are worthy of explanations. For example, physical educators and coaches can "help young people feel good about themselves and to accept others" through creating a supportive emotional climate in the classroom and the sports arena. Books, like *Fostering Emotional Well-Being in the Classroom* (Page & Page, 1993) provide educators with specific strategies for creating a supportive environment which will enhance young people's self-esteem.

Physical educators and coaches are presented with a difficult challenge—to prevent and detect eating disorders. Thus, to meet the challenge, physical educators and coaches must take it upon themselves to:

1. Know the signs, symptoms and characteristics of eating disorders.
2. Develop the ability to identify and refer individuals with eating disorders.
3. Market and implement fitness management rather than weight reduction, addressing the fact that being underweight is equally as hazardous as being overweight.
4. Incorporate healthy alternatives to exercise, i.e., relaxation, music, to relieve stress.
5. Advocate realistic weight goals through participation in a healthy, moderate exercise program.
6. Present themselves as role models (Moriarty, Ford, Rawlings, 1991).

In Overeater's Anonymous, a self-help group for eating disorders, members say, "when you are addicted to alcohol you put the tiger in the cage to recover, when you are addicted to food you put the tiger in the cage, but take it out three times a day for a walk" (Yeary, 1987). Physical educators and coaches are in a position to foster a healthy body-image, develop a positive self-image, and determine a realistic body weight for individuals through sound nutritition and exercise education. Physical educators and coaches can empower individuals to take the tiger by the tail.

References

Bayer, A.E. (1984). Eating out of control: Anorexia and bulimia in adolescents. *Children Today, 13*(6), 7-11.

Boskind-White, M. & White, W. (1983). *Bulimiarexia: The Binge/Purge Cycle.* New York: Norton.

Bruch, H. (1979). *The Golden Cage: The Enigma of Anorexia Nervosa.* New York: Vintage Books.

Collins, M.E. (1988). Education for healthy body weight: Helping adolescents balance the cultural pressures for thinness. *Journal of School Health, 58*(6), 227-230.

Doane, H.M. (1983). *Famine at the Feast: A Therapist's Guide to Working with the Eating Disordered.* Ann Arbor, MI. (Eric Document Reproduction Service No. 239 191 CG 017 397).

Fontaine, K.L. (1991). The conspiracy of culture: Women's issues in body size. *Nursing Clinics of North America, 26*(3), 669-676.

Haller, E. (1992). Eating Disorders: A review and update. *The Western Journal of Medicine, 157*(6) 658-662.

House of Representatives, Select Committee on Children, Youth, and Families. (1987). *Eating Disorders: The Impact on Children and Families.* Washington. (Eric Document Reproduction Service No. ED 294 092 CG 020 758).

Lindsey, B.J. & Janz, K.F. (1985). A healthy connection: Helping physical educators address eating disorders. *Journal of Physical Education, Recreation, and Dance, 56,* 41-44.

Moriarty, D., Ford, C., & Rawlings, J. (1991). *Recent Research on Eating Disorders and Body Image Distortion Among Aerobic Dance Instructors and Exercise Participants.* Subbury, Ontario. (Eric Document Reproduction Service No. ED 335 601 CG 023 594).

Nagel, K.L. & Jones, K.H. (1992). Sociological factors in the development of eating disorders. *Adolescence, 27*(105), 107-113.

National Live Stock and Meat Board (1992). *Mirror, Mirror.* Chicago, IL: Education Department of National Live Stock and Meat Board.

Ogletree, S.M., Williams, S.W., Raffeld, P., Mason, B., & Fricke, K. (1990). Female attractiveness and eating disorders: Do children's television commercials play a role. *Sex-Roles: A Journal of Research, 22* (11-12), 791-797.

Page, R.M. & Page, T.S. (1993). *Fostering Emotional Well-Being in the Classroom.* Boston: Jones & Barlett Publishers.

Perdue, L. & Silverstein, B. (1985). *A Comparison of the Weights and Ages of Women and Men on Television.* (ERIC Document Reproduction Service No. ED 262 300 CG 018 535).

Rapheale, F.J. & Lacey, P.D. (1992). Depression, dietary restraint, and binge eating in female runners. *Addictive Behavior, 16,* 295-301.

Richards, P.S. (1985). *The Treatment of Anorexia Nervosa and Bulimia: A Multidimensional Group Approach.* Minneapolis, MN. (Eric Document Reproduction Service No. ED 277 931 CG 019 613).

Round Table. (1985). Eating disorders in young athletes. *The Physician and Sportsmedicine, 13*(11), 89-106.

Shisslak, C.M., Crago, M., Neal, M.E., & Swain, B. (1987). Primary prevention of eating disorders. *Journal of Counseling and Clinical Psychology, 55*(5), 660-667.

Silverstein, B., Peterson, B., & Perdue, L. (1986). Some correlates of the thin standard of bodily attractiveness for women. *International Journal of Eating Disorders, 5*(5), 895-905.

Waller, G., Hamilton, K., & Shaw, J. (1992). Media influences on body size estimation in eating disordered and comparison subjects. *British Review of Bulimia and Anorexia Nervosa, 6*(2), 81-87.

Yates, A. (1992). Biological consideration in the etiology of eating disorders. *Pediatric Annals, 21*(11), 739-744.

Yeary, J. (1987). The use of overeaters anonymous in the treatment of eating disorders. *Journal of Psychoactive Drugs, 19*(3), 303-309.